Policy Name	Policy Number:
TRACHEOSTOMY: MANAGEMENT, CARE AND TRACHEAL SUCTIONING	**0272**
	Effective Date: January 6, 2010
Approved By: Management Committee	Date Revised:
Classification: Pain and Symptom Control	Page No: Page 1 of 5

POLICY

In hospice/palliative care, for a resident with a tracheostomy, trach management, care and suctioning is done to maintain a patent airway, facilitate the removal of secretions, prevent infection and skin break down at the stoma site. Suctioning is indicated ***only*** when a resident is unable to clear secretions independently. It ***should not*** be done on a routine basis and installation of saline ***is not*** done routinely.

At Agapé Hospice, a Registered Nurse can perform trach management, care and suctioning using clean technique. This includes the use of clean gloves, sterile suction catheter and normal saline or distilled water in a clean container. Suction equipment must remain set up at the resident's bedside at all times. Tracheostomy care/dressing change should be done when tracheal suctioning is completed or, at a minimum, every shift.

DEFINITIONS

Tracheostomy - A surgical opening in the trachea forming a passageway for air.

Inner Cannula - Tracheostomy tubes often have two parts. An inner cannula fits inside the tracheostomy tube and can be removed to clean.

Obturator -The semi-rigid stick put into the tracheostomy tube to help guide it into the opening in the neck.

Fenestration - An opening or hole. A fenestrated tracheostomy tube has a perforation in it allowing air to pass to and from the upper airway (nares and mouth).

Tracheostomy tie - An around the neck fastener, for the purpose of holding the tracheostomy tube in place. There are many different types of trach ties.

Trach Cradle (mask)- A specialized mask allowing for the delivery of oxygen or humidified air to a tracheostomy.

Trach Button - Is a ½ inch to 1½ inch long plastic tube inserted into a tracheostomy to keep it open.

TRACHEOSTOMY CARE

1. Residents with a tracheostomy should have a spare tracheostomy tube in a readily accessible and visible location at the bedside (ie: taped to the head of the bed).

******Tracheostomy parts are not interchangeable.
Replacement tubes must be kept unopened until needed.

2. The trach obturator, from the tracheostomy tube currently in place, should be in a readily accessible and visible location (ie: taped to the head of the bed).
3. Suction equipment must be available and set up at the bedside at all times.
4. In the event of an emergency where the airway is compromised due to an accidental decannulation, the nurse may attempt to reinsert the tracheostomy tube. The attending physician or designate must be notified as soon as possible.
5. Appropriated communication devices, such as pen and paper, must be accessible for residents with a tracheostomy.
6. Trach dressings are changed daily, at a minimum, and as needed. It can be done at the same time as suctioning.
7. Trach ties should be tight enough to secure the tube and loose enough to prevent skin breakdown and vascular obstruction. Ties should be adjusted so that two (2) fingers can be inserted beneath the tie.

*****It is recommended that two people are present when changing trach ties.*****

DRESSING CHANGE AND TRACHEOSTOMY CARE PROCEDURE

1. Prepare supplies:
   - Tracheostomy care tray,
   - Normal saline,
   - Hydrogen peroxide,
   - Tracheostomy ties,
   - Cotton tipped applicators (Q-Tips),
   - Personal protective equipment (PPE) as necessary including surgical mask and eye protection. N95 mask should be used if **influenza like illness** (ILI) is suspected.
2. Position the resident supine, if tolerated.
3. Remove trach cradle, but leave the oxygen flow directed at the tracheostomy.
4. Wash hands and don gloves.
5. Remove the old dressing if present and discard.
6. Wash hands and re-glove.

7. Remove the inner cannula, if present. Soak it in a solution of normal saline or half strength hydrogen peroxide (half normal saline, half hydrogen peroxide).
8. Cleanse around the stoma with Q-tips and/or gauze soaked in normal saline. Discard the Q-tip or gauze after one use.
9. Dry the site thoroughly. Apply ointment around stoma site if ordered by the physician.
10. Change the trach ties as needed. The tracheostomy ***must*** be held in place by a second person while the ties are changed.
11. Apply a single trach dressing (drain sponge) using forceps to position the dressing under the flange.

*****Use only precut drain sponges or keyhole dressings around the stoma. These dressings reduce the risk of dressing fibers entering the stoma.*****

12. Clean the inner cannula with the disposable chenille cleaners, brush or gauze. Rinse the inner cannula well in normal saline, thoroughly removing any hydrogen peroxide. Shake off the excess moisture and reinsert the inner cannula ensuring that it is locked in place.
13. Replace oxygen and/or humidification device.
14. If suctioning is not required, discard disposable equipment, remove PPE, wash hands and document the procedure as well as the resident's tolerance, in the resident's progress notes, in their health record.

****If suctioning is required, tracheal suctioning should be done prior to the trach care.****

POINTS TO REMEMBER WHEN SUCTIONING

1. It is necessary to insert a non-fenestrated inner cannula prior to suctioning through a fenestrated trach tube to prevent passing the suction catheter through the fenestration and harming tracheal tissue.
2. Established tracheostomies with a long term tracheal cannula (tracheal button) in place ***should not*** be suctioned to prevent injury to the bronchus.
3. The nasopharynx, which provides the natural humidification mechanism for the airway, is bypassed with a tracheostomy, therefore external humidification may be required. This can be supplied by, but is not limited to, nebulized sterile water, heat and moisture exchangers, heated humidifiers and tracheal bibs/cradles.
4. Tracheal suctioning can lead to complications such as: hypoxia, hypotension, vagal stimulation, cardiac dysrhythmias, tracheal trauma, tracheal bleeding, atelactasis and infection.

SUCTIONING PROCEDURE

1. Assess need for suctioning:
   - lung auscultation,
   - respiratory rate and pattern,
   - obvious secretions,
   - audible respirations,
   - decreased O2 saturation,
   - shortness of breath (increased work of breathing).
2. Position the resident sitting as upright as possible, unless contraindicated.
3. Wash hands.
4. Don personal protective equipment (PPE), including surgical mask and eye protection. If **influenza like illness** (ILI) is suspected, a N95 mask and eye protection must be used.
5. Prepare necessary equipment:
   - ensure that suction equipment is working,
   - pour normal saline or distilled water into a clean container,
   - connect suction tubing to suction catheter while maintaining aseptic technique.
6. Lubricate the suction catheter by flushing normal saline or distilled water through the tubing.
7. Remove resident's oxygen and/or humidification device as necessary.
8. If a fenestrated tracheostomy tube is in place, a non-fenestrated inner cannula needs to be in place for suctioning. If there is a non-fenestrated tracheostomy tube in place, suctioning may be done without the inner cannula.
9. Insert suction catheter into tracheostomy, ***without applying suction.*** Advance the suction catheter until resistance is met (the carina) and pull back approximately one (1) centimeter.

******Care should be taken to avoid repeatedly hitting the carina as this can cause a considerable amount of trauma to the area******

10. If resistance to suction catheter insertion is met before reaching **15 centimeters,** suspect an obstruction related to build up of mucous, tube kinking, lying against tissue or incorrect resident position. Withdraw the suction catheter, remove the inner cannula, if in place, inspect and clean as necessary. Reposition the resident. Attempt suctioning again.
11. Instruct the resident to take a deep breath and cough if able.
12. Withdraw the suction catheter applying suction. Time from insertion to complete withdrawal ***should not exceed 10-15 seconds.***
13. Replace oxygen if being used by the resident and allow the resident to take a few breaths between suction attempts.

14. Rinse the suction catheter in the container by flushing with normal saline or distilled water.
15. Reassess the resident. If a second repeated suctioning of the tracheostomy is required, use the same catheter.

******Suctioning the tracheostomy more than 2 to 3 times per session is not recommended.******

16. Provide mouth care as required.
17. Ensure oxygen and/or humidification is reapplied.
18. Reassess the resident's respiratory status.
19. Discard disposable equipment. Remove PPE equipment. Wash hands.
20. Document in the progress notes section of the resident's health record:
    - Assessment of resident's respiratory status prior to suctioning,
    - number of suction passes,
    - quality, colour, consistency and odor of secretions,
    - dressing change,
    - appearance of skin around the stoma,
    - resident's respiratory assessment following the procedure,
    - resident's tolerance of the procedure.

REFERENCE

Alberta Health Service, Calgary Zone – Tracheostomy Management and Care, Policy Number T-1

Alberta Health Services, Calgary Zone – Tracheostomy: Tracheal Suctioning and Humidification, Policy Number T-2.